MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7584 (07584)

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 27
HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carrell
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural, give location) 121 Main St.

3. NAME OF DECEASED: (Type or Print) (First) NETTIE (Middle) VIOLA (Last) BAIRD

4. DATE OF DEATH: (Month) August (Day) 4 (Year) 19 55

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: October 25, 1891

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sorter

10b. KIND OF BUSINESS OR INDUSTRY: Laundry

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christopher Fields

14. MOTHER'S MAIDEN NAME: Carolyn Regan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Irma Harper 603 Linnard St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 181X Cancer of the bladder — INTERVAL BETWEEN ONSET AND DEATH: 6 mo. (7)

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 26, 19 55, to Aug. 4, 19 55, that I last saw the deceased alive on Aug 3, 19 55, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE James T. Marsh (DEGREE OR TITLE) M.D. ADDRESS Westminster Md DATE SIGNED Aug 4/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug. 8 1955 — NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk. — LOCATION (City, town, or county) (State): Elkridge, Md.

DATE REC'D BY LOCAL REG. August 6, 1955 — REGISTRAR'S SIGNATURE R. W.

24. FUNERAL DIRECTOR — ADDRESS: John F. Denny, Inc. 715 Light St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07585

7587 **CERTIFICATE OF DEATH** Reg. Dist. No. 78

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - near Taylorsville
LENGTH OF STAY (in this place) 6½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Route 1 - New Windsor

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - near Taylorsville X
STREET ADDRESS (If rural give location) Route 1 - New Windsor

3. NAME OF DECEASED: (First) Reuben (Middle) Henry (Last) Baker

4. DATE OF DEATH: (Month) August (Day) 25 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH: June 28, 1898 | 9. AGE last birthday 57 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Reuben Sidwill Baker
14. MOTHER'S MAIDEN NAME: Mary Catherine Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-24-8073
17. INFORMANT & ADDRESS: Ruth Emily Smith Route 1 - New Windsor Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 023X (A) Luetic Aortitis with Decompensation — INTERVAL BETWEEN ONSET AND DEATH: More than 3 years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1953, to August, 1955, that I last saw the deceased alive on August 4, 1955, and that death occurred at 7 A. M, from the causes and on the date stated above.

SIGNATURE W B Culwell M. D. ADDRESS Mt. Airy, Md DATE SIGNED Aug. 25, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Aug 27-1955 | NAME OF CEMETERY OR CREMATORY Taylorsville Cem. | LOCATION (City, town, or county) (State) Taylorsville Maryland

DATE REC'D BY LOCAL REGISTRAR 8-25-55 | REGISTRAR'S SIGNATURE E. M. Farver | 24. FUNERAL DIRECTOR ADDRESS D D Hartzler & Sons New Windsor Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07586

7588 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 2/13/48
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 2901 Ailsa Avenue

3. NAME OF DECEASED: (Type or Print) (First) Norman (Middle) Allen (Last) BANDEL

4. DATE OF DEATH: (Month) August (Day) 8 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: September 3, 1891
9. AGE last birthday 63 yrs.
IF UNDER 1 YEAR: Months —
IF UNDER 24 HRS.: Days — Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Collector
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): United States
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GeorgeBandel
14. MOTHER'S MAIDEN NAME: Sallie Bruscup

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
025X IMMEDIATE CAUSE	(A) Bronchopneumonia	5 days
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) General paresis	9 yrs.
	DUE TO	
	(C) Syphilis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with syphilitic meningo-encephalitis		More than 7 yrs.

19A. DATE OF OPERATION: ---
19B. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---
21C. WHERE DID INJURY OCCUR? (City or town) --- (County) --- (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Aug. 24, 1948, to Aug. 7, 1955, that I last saw the deceased alive on Aug. 7, 1955, and that death occurred at 1:50 A M, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M. D. M. D. ADDRESS Sykesville, Md. DATE SIGNED 8/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-10-55
NAME OF CEMETERY OR CREMATORY Baltimore
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 8, 1955
REGISTRAR'S SIGNATURE C. Harry Eller
24. FUNERAL DIRECTOR H. Sanderson - North & Broadway - Bal
ADDRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07587

7589

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X rural--Sykesville
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: OS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural--Sykesville
STREET ADDRESS (If rural, give location): Gist

3. NAME OF DECEASED (Type or Print): (First) EMIL (Middle) O (Last) BARNES

4. DATE OF DEATH: (Month) AUG. (Day) 23 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 9-11-1881

9. AGE last birthday: 73 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer retired

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John T. Barnes

14. MOTHER'S MAIDEN NAME: Caroline Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: 213-18-8760

17. INFORMANT AND ADDRESS: Mrs. Gertie Barnes, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) cerebral hemorrhage — Interval Between Onset and Death: 2 weeks

Antecedent cause(s) (b) arteriosclerosis — 5 or 6 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19 49, to 8/23/55, that I last saw the deceased alive on Aug 22, 1955, and that death occurred at 11:30 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title): Lee Wolkens M.D. — ADDRESS: Westminster — DATE SIGNED: 8/23/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 8-26-1955 — NAME OF CEMETERY OR CREMATORY: Bethesda — LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE REC'D BY LOCAL REG.: Aug 25-1955 — REGISTRAR'S SIGNATURE: Robert B. Hewitt

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07588

7590 **CERTIFICATE OF DEATH** Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1 y 11 m 13 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfiedd State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 3Y01-4
STREET ADDRESS (If rural give location) 1719 N.Port Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) C. (Last) Burton
4. DATE OF DEATH: (Month) 8 (Day) 28 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: 1 - 16 - 70
9. AGE last birthday 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William S. Arnold
14. MOTHER'S MAIDEN NAME: Anna V. Younger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1
IMMEDIATE CAUSE (A) Cerebral hemorrhage — days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic cardiovascular disease — years
DUE TO
(C) Genaralized Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Chr.brain syndr.ass.with senile brain dis. with psych. reactions — years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7- 18- , 1955, to 8 - 27 - 1955, that I last saw the deceased alive on 8 - 27 - , 1955, and that death occurred at 1:00 AM, from the causes and on the date stated above.
SIGNATURE Edmund Lusthaus
Edmund Lusthaus M.D.
ADDRESS Springfield State Hospital
DATE SIGNED 8 - 28 - 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug. 31, 1955
NAME OF CEMETERY OR CREMATORY Foster Cemetery
LOCATION (City, town, or county) (State) Hereford, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-5-55
REGISTRAR'S SIGNATURE W. Hedrick
24. FUNERAL DIRECTOR ADDRESS Wm. J. Tickner & Sons, Balto., Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07589

7591 CERTIFICATE OF DEATH Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 30 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3X01-4
STREET ADDRESS (If rural give location) 3006 Harlem Avenue

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) Frederick (Last) Caulk
4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 19 55
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 3-17-1896
9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Janitor
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Ellis Hall
14. MOTHER'S MAIDEN NAME: Unknown
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) I
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Carrie Johnson, 3006 Harlem Avenue

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

002X
Immediate cause (a) Far advanced bilateral cavitary tuberculosis
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-5-, 19 55, to 8-4-, 19 55, that I last saw the deceased alive on 8-4-, 19 55, and that death occurred at 6:05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. F. Postal, M.D ADDRESS Henryton, Maryland DATE SIGNED 8-4-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8-8-55 NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. LOCATION (City, town, or county) Brooklyn Md (State)

DATE REC'D BY LOCAL REGISTRAR 8-4-55 REGISTRAR'S SIGNATURE Albert R. Swanktand

24. FUNERAL DIRECTOR Edwyn O. Wilson ADDRESS 1044 Brooklyn Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07590

7592

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 5 Mos. 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-56-2
STREET ADDRESS (If rural give location) 10403 Huntley Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Henry (Last) CONWELL

4. DATE OF DEATH: (Month) 8 (Day) 18 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 1/1/78

9. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Conwell

14. MOTHER'S MAIDEN NAME: Sarah Allgood Conwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
IMMEDIATE CAUSE (A) Arteriosclerotic heart disease — years
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Bronchopneumonia — 5 days
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychosis — 2 years?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/13, 19 55 to 8/18, 19 55 that I last saw the deceased alive on 8/18, 19 55, and that death occurred at 9:30 P DST M, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt M. D. ADDRESS Sykesville, Maryland DATE SIGNED 8/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/22/55 | NAME OF CEMETERY OR CREMATORY Fort Lincoln | LOCATION (City, town, or county) (State) Colmar Manor, Md

DATE REC'D BY LOCAL REGISTRAR 8/19/55 | REGISTRAR'S SIGNATURE C. Harry Weed | 24 FUNERAL DIRECTOR J. Gasch's Sons Hyattsville | ADDRESS Md

07591

7593

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Taneytown; LENGTH OF STAY (in this place): lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Taneytown X
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jennie	K.	Copenhaver	August 21, 1955 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Married	12/20/1872	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Haifley	Clarissa Stonesifer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	William M. Copenhaver, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Chronic myocarditis – myocardial degeneration.	10 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	10 yrs
	(c) Cerebral arteriosclerosis	10 yrs
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Debility, Senile	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-5, 1946, to 8-21-, 1955, that I last saw the deceased alive on 8-20, 1955, and that death occurred at 11:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E. Ambler Thompson		Taneytown, Md.	8-24-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 24, 1955	United Bretheran Cemetery	Taneytown, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
August 24, 1955	Ethel M Mehring Local	C.O.Fuss & Son, Taneytown, Maryland

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ... especially important. Physicians: please write the causes of death clearly and legibl...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8537

CERTIFICATE OF DEATH

08540

Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) more than 47 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN not known 11X-2
STREET ADDRESS (If rural give location) not known ✓

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) (Last) Davis

4. DATE OF DEATH: (Month) 8 (Day) 31 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single
8. DATE OF BIRTH: 2 2 1889
9. AGE last birthday 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Garrett County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Davis
14. MOTHER'S MAIDEN NAME: Catherine Bray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X
IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Epithelioma of skin with metastasis unknown; Convulsive disorder with psychosis 47 yr

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1955 to Aug 31, 1955 that I last saw the deceased alive on August 31, 1955, and that death occurred at 7 10 PM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 9/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL
DATE THEREOF SEPT 12 1955
NAME OF CEMETERY OR CREMATORY U of M MEDICAL SCHOOL
LOCATION (City, town, or county) 29 S GREEN ST (State) MD

DATE REC'D BY LOCAL REGISTRAR Sept. 13, 1955
REGISTRAR'S SIGNATURE C. Harry Keefe
24. FUNERAL DIRECTOR Duffel Bro ADDRESS 1800 E LOMBARD ST

correct age is especially

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07592

7594 CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): X Henryton
LENGTH OF STAY (in this place): 121 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: WC
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 3V01-4
STREET ADDRESS (If rural give location): 1634 N. Smallwood Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Susie (Middle) Rebecca (Last) Dawson

4. DATE OF DEATH: (Month) 8 (Day) 21 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 12-4-1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private Home

11. BIRTHPLACE (State or foreign country): Lancaster, Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Edgar Smith

14. MOTHER'S MAIDEN NAME: Elizabeth Thornton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Susie R. Dawson - 1634 N. Smallwood Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

012.0

Immediate cause (a) Tuberculosis of the thoracic Spine

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-22-, 1955, to 8-21-, 1955, that I last saw the deceased alive on 8-21-, 1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): T.F. Leopal M.D

ADDRESS: Henryton, Maryland

DATE SIGNED: 8-21-55

23. BURIAL, CREMATION, REMOVAL (Specify): Buriel

DATE THEREOF: 8-25-55

NAME OF CEMETERY OR CREMATORY: Family Lot

LOCATION (City, town, or county) (State): Whitestone, Virginia

DATE REC'D BY LOCAL REGISTRAR: 8-21-55

REGISTRAR'S SIGNATURE: Albert R. Smallwood

24. FUNERAL DIRECTOR: Holland Funeral Home

ADDRESS: 1631 Druid Hill Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07593

7595 CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg
STREET ADDRESS (If rural give location) Rural

3. NAME OF DECEASED: (Type or Print) (First) SAMUEL (Middle) EMORY (Last) DIEHL

4. DATE OF DEATH: (Month) Aug. (Day) 29 (Year) 1955

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower | 8. DATE OF BIRTH: 9/30/1867 | 9. AGE last birthday: 87 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): farmer retired

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William S. Diehl

14. MOTHER'S MAIDEN NAME: Emma —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mary F. Hartsock, Middleburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

331X
Immediate cause (a) Cerebral Hemorrhage
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c) Senile Debility

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 55, to Aug 29, 1955, that I last saw the deceased alive on Aug 29, 1955, and that death occurred at 5 a.m., from the causes and on the date stated above.

SIGNATURE J. F. Strawsburg M.D. (Degree or title) ADDRESS Union Bridge Md DATE SIGNED Aug 29

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 8/31/55 | NAME OF CEMETERY OR CREMATORY Pipe Ridge Church Cem. | LOCATION (City, town or county) Union Bridge | (State) Md

DATE REC'D BY LOCAL REGISTRAR Aug. 30, 1955 | REGISTRAR'S SIGNATURE Leslie L. Repp

24. FUNERAL DIRECTOR D. D. Hartsock & Son | ADDRESS Union Bridge, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

7596

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07594

Reg. Dist. No. 75

M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll, MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]; LENGTH OF STAY (in this place) [illegible]; HOSPITAL OR INSTITUTION OR STREET ADDRESS	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead; STREET ADDRESS (If rural, give location) R.F.D. ([illegible])
3. NAME OF DECEASED (Type or Print) (First) RAY (Middle) EARL (Last) DUIBS	4. DATE OF DEATH (Month) Aug (Day) 21 (Year) 1955
5. SEX M; 6. COLOR OR RACE W; 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH Oct 10-1940; 9. AGE last birthday 14 yrs.; If under 1 year Months, Days; If under 24 hrs Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schooling; 10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland; 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John L. Duibs	14. MOTHER'S MAIDEN NAME Elizabeth M. Hilker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service); 16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS John L. Duibs Hampstead, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
929.9 Immediate cause	(a) Drowning	—
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [illegible]	(CITY OR TOWN) Lineboro (COUNTY) Carroll (STATE) Md
TIME OF INJURY (Month) 8 (Day) 21 (Year) 55 (Hour) ? P m. INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR? Drowned

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Marsh	Deputy Med Examiner	Westminster Md	8/21/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8/24/55	Lazarus Union	Lineboro	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 22/55	Mrs. H. R. Deener	H. [illegible] & Son	Glen Rock, Pa

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07595

7597 CERTIFICATE OF DEATH Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN X Rural, Westminster
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Jamison Road Wilmot Building Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster X
STREET ADDRESS (If rural give location) Spring Mills

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) — (Last) FRANKLIN

4. DATE OF DEATH: (Month) Aug. (Day) 4 (Year) 19 55

5. SEX: M.

6. COLOR OR RACE: White Male

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: ?

9. AGE last birthday: 88 yrs. IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Farm Labourer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Franklin

14. MOTHER'S MAIDEN NAME: Mary Reese

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Harvey L. Reese, Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 434.2 (a) Myocardial (Coronary) Thrombosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis

DUE TO

(c)

Interval Between Onset And Death: 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1955, to Aug. 4, 1955, that I last saw the deceased alive on Aug 3, 1955, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. C. Jamutte M.D. — ADDRESS Westminster Md — DATE SIGNED Aug 4-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Aug. 6-55 — NAME OF CEMETERY OR CREMATORY Baders Cemetery — LOCATION (City, town, or county) (State) Rural, Westminster

DATE REC'D BY LOCAL REGISTRAR 8-4-55 — REGISTRAR'S SIGNATURE Hazel Wallen

24. FUNERAL DIRECTOR J. E. Myers Jr. — ADDRESS Westminster Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07596

7598 CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 18 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 568 Balto. Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural give location) 568 Balto. Blvd.

3. NAME OF DECEASED: (Type or Print) (First) NATHAN (Middle) WARNER (Last) GILLETTE

4. DATE OF DEATH: (Month) Aug. (Day) 31 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: July 26 1896

9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Industrial engineer

10b. KIND OF BUSINESS OR INDUSTRY: Sylvania Corp.

11. BIRTHPLACE (State or foreign country): Boston Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rev. Wallace Gillette

14. MOTHER'S MAIDEN NAME: Harriett Hawthorne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) World War I.

16. SOCIAL SECURITY No.: 013-05-1493

17. INFORMANT & ADDRESS: Mrs. Esther W. Gillette, Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: Instant

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Coronary Sclerosis — Coronary Thrombosis — 1946

DUE TO

(c) Arteriosclerosis & Hypertension — Prob 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) (Degree or title) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1955, to Aug. 31, 1955, that I last saw the deceased alive on Sept. 1, 1955, and that death occurred at 10:00 P.M., Aug. 31-55, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William Sperry, M.D. Westminster Md 9-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation — DATE THEREOF Sept. 5, 55 — NAME OF CEMETERY OR CREMATORY London Park — LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR 9-2-55 — REGISTRAR'S SIGNATURE Hamet Miller

24. FUNERAL DIRECTOR J. E. Myers, Jr. — ADDRESS Westminster Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07597

7599 **CERTIFICATE OF DEATH**

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 4 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadowview Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster R. D. 3
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) MARGARET (Last) GREEN

4. DATE OF DEATH: (Month) August (Day) 29 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan. 14, 1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Plee

14. MOTHER'S MAIDEN NAME: Mary Onitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Herman F. Green 109 E. Main Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause (a)	Coronary Thrombosis	15 min
Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. DUE TO (b)	Arteriosclerosis Coronary & Cerebralis	3 yrs
DUE TO (c)	Chronic Heart Disease	5 yrs
	Arthritis multiple	10 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1949, to August 29 1955, that I last saw the deceased alive on Aug. 29, 1955, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) William E. Speicher M.D. ADDRESS Westminster Md. DATE SIGNED 8/31/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — **DATE THEREOF** Sept. 1 1955 — **NAME OF CEMETERY OR CREMATORY** Westminster Cemetery — **LOCATION** (City, town, or county) (State) Church St. Westminster Md

DATE REC'D BY LOCAL REGISTRAR 9-1-55 — **REGISTRAR'S SIGNATURE** Hazel Miller

24. FUNERAL DIRECTOR H. Bankard & Son — **ADDRESS** Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7610

CERTIFICATE OF DEATH

07598
Reg. Dist. No. 82-83

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt Airy - RURAL
LENGTH OF STAY (in this place) 46yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY CARROLL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Mt. Airy X
STREET ADDRESS (If rural give location) NEAR - Woodbine

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) MAURICE (Last) HESS

4. DATE OF DEATH: (Month) Aug (Day) 7 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Feb 2. 1879

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10B. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Taneytown, Maryland

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Samuel Francis Hess

14. MOTHER'S MAIDEN NAME: Priscilla Rebecca Bushey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: Mrs. Daisy M. Hess, same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) Cerebral hemorrhage, arteriosclerosis

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) hypertension, cardiac arrest

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 Aug, 1955, to 7 Aug, 1955, that I last saw the deceased alive on 7 Aug, 1955, and that death occurred at 9:30 PM, from the causes and on the date stated above.

SIGNATURE Howard E Hall M. D. ADDRESS Sykesville, Md. DATE SIGNED 7 Aug 55

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) BURIAL

DATE THEREOF 8-11-1955

NAME OF CEMETERY OR CREMATORY Mt. Olivet

LOCATION (City, town, or county) (State) Frederick, Md.

DATE REC'D BY LOCAL REGISTRAR Aug 10-55

REGISTRAR'S SIGNATURE Robert R. Hewitt.

24. FUNERAL DIRECTOR C. M. Waltz

ADDRESS Winfield, Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07599

7691

CERTIFICATE OF DEATH

Reg. Dist. No.....

Item 2, FilmG185 8-22-55 et Items 8,9, FilmG185 8-26-55 et

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Finksburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Finksburg~~ Baltimore City 3V01-4; STREET ADDRESS (If rural, give location) ~~Finksburg Nursing Home~~ 218 Hawthorne Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
REBECCA	Slade	HOSHALL	August	9	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	June 22, ~~1877~~ 1872	80 83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Glenncoe, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Henry Harrison Anderson	Elizabeth Slade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO		Mr. Edward M. Hoshall, 218 Hawthorne Road

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchial Pneumonia (Terminal)	24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic C.V. Disease	5 yrs.
↓	(c) Abdominal Mass (etiology undetermined)	6 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 22, 1954, to Aug. 9, 1955, that I last saw the deceased alive on August 9, 1955, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin E. Strobel	M.D.	Reisterstown, Md.	8/9/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 12, 1955	Woodlawn Cemetery	Woodlawn, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-12-55	Alice Hebert	Wm. J. Tickner & Sons	Balto. 17, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07600

7602 **CERTIFICATE OF DEATH** Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Caroll MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY 3V01-4

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City

STREET ADDRESS (If rural give location) 1200 Valley St. #2

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Thomas (Last) Hudson

4. DATE OF DEATH: (Month) 8 (Day) 12 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10-3-1892

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months 10 Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Cashier

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Robert Hudson

14. MOTHER'S MAIDEN NAME: Anna Hudson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Little Sisters of the Poor 1200 Valley St. Balto. 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Acute Cardiac Failure

DUE TO Chronic Hypertensive C-V Disease

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO (c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18, 1955, to 8-12, 1955, that I last saw the deceased alive on 8-12, 1955, and that death occurred at 6:15 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Sommerfield M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug 16/55 NAME OF CEMETERY OR CREMATORY Mount Olivet LOCATION (City, town, or county) (State) Baltimore Md

DATE REC'D BY LOCAL REGISTRAR 8-13-55 REGISTRAR'S SIGNATURE [illegible] 24. FUNERAL DIRECTOR Rite Wiedefeld ADDRESS 405 E. Biddle St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07601

7585

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
LENGTH OF STAY (in this place) 20 yrs.
27
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 E. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
27
STREET ADDRESS (If rural give location) 103 E. Main St.
1

3. NAME OF DECEASED: (Type or Print) (First) C. (Middle) RAYMOND (Last) J ENKINS

4. DATE OF DEATH: (Month) AUG. (Day) 1, (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-22-1889

9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Clerk

10B. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wesley Jenkins

14. MOTHER'S MAIDEN NAME: Eliza Jane Hartley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-3771

17. INFORMANT & ADDRESS: Burnell Jenkins, Manchester, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

431X IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 7 min 7-27-55

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Syphilis (aorta) — 7 yrs

(C) DUE TO Myocarditis (aorta) — 7 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? 28 Wed

22. I hereby certify that I attended the deceased from 7-28-, 1955, to 8-1-, 1955, that I last saw the deceased alive on 7-31-, 1955, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE W. C. Jamutte M.D. ADDRESS Westminster Md DATE SIGNED 8-2-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — DATE THEREOF 8-4-1955 — NAME OF CEMETERY ~~OR CREMATORY~~ Ebenezer — LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR 8-3-55 — REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR C. M. Waltz, ADDRESS Winfield, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07602

CERTIFICATE OF DEATH

76 3

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN X Henryton

LENGTH OF STAY (in this place) 8 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland

STREET ADDRESS 22 X - 2 (If rural give location) ✓

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH:	(Month)	(Day)	(Year)
	Richard		Johnson		8	2	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Negro	Married	12-6-1906	48 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Mill	Miami, Florida	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Johnson	Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	218-32-1995	Richard Johnson, Fruitland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

002X

Immediate cause (a) Cardiac insufficiency

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Far advanced bilateral pulmonary tuberculosis.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-25, 1955, to 8-2-, 1955, that I last saw the deceased alive on 8-2-55, 19..., and that death occurred at 8:20 a.m., from the causes and on the date stated above.

SIGNATURE T. F. Leahy M.D (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 8-2-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Aug 2/55	Fruitland	Wicomico Co. Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-2-55	Albert R. Swankhauser	J. B. Johnson	Hebron Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07603

7604

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 2/24/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY -
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 245 Dallas Court

3. NAME OF DECEASED: (Type or Print) (First) Zach (Middle) Alexander (Last) JOHNSON

4. DATE OF DEATH: (Month) August (Day) 12 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): separated

8. DATE OF BIRTH: October 26, 1881

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS.: Hours - Min. -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch repairman

10B. KIND OF BUSINESS OR INDUSTRY: Watch

11. BIRTHPLACE (State or foreign country): Lynchburg, Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joe Johnson

14. MOTHER'S MAIDEN NAME: Clara Trent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X

IMMEDIATE CAUSE (A) Carcinoma of Stomach with metastases to liver and lung — INTERVAL BETWEEN ONSET AND DEATH: about 6 mo

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis 6yr

19A. DATE OF OPERATION: ---

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work [ ] Not while at work [ ] ---

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from July 22, 1950 to Aug. 12, 1955 that I last saw the deceased alive on Aug. 12, 1955, and that death occurred at 2:15 PM, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. — Martin Gross, M.D. — ADDRESS Sykesville, Maryland — DATE SIGNED 8/12/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug. 15, 1955 — NAME OF CEMETERY OR CREMATORY St. Paul's — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 13, 1955 — REGISTRAR'S SIGNATURE C. Harry Weed

24. FUNERAL DIRECTOR Wm. Cook, Inc. — ADDRESS 1217 N. Paca St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7604 7605

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 3Y 10M 28 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus
STREET ADDRESS (If rural give location) 15X-2 ✓

3. NAME OF DECEASED: (First) Amy (Middle) Matrona (Last) JONES
4. DATE OF DEATH: (Month) 8/ (Day) 18 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 9/7/81
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Montgomery Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rufus F. King
14. MOTHER'S MAIDEN NAME: Ursala King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) York - (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. York -
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) Acute myocardial infarction	instant
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Chronic myocardial infarction	month
	DUE TO (C) pulmonary edema and bronchopneumonia	hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction	5 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/16, 1955 to 8/18, 1955, that I last saw the deceased alive on 8/17, 1955, and that death occurred at 12:15 AM DST, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt M. D. ADDRESS Sykesville, Maryland DATE SIGNED 8/18/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug. 21, 1955
NAME OF CEMETERY OR CREMATORY Damascus
LOCATION (City, town, or county) (State) Damascus, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 19, 1955
REGISTRAR'S SIGNATURE C. Harry Klee
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.

VS. A15—10-53

7606 07605

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 40 y 11 m 18 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore City 3V01-4
STREET ADDRESS (If rural, give location) 3333 N. Charles Street

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) J. (Last) Kidd

4. DATE OF DEATH (Month) 8 (Day) 26 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	single	MAY 25, 1875	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
clerk		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Kidd	Mary Crane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	NONE	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause 9367	(a) DUE TO Pulmonary embolism	hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Bronchopneumonia, beginning	hours
	(c) Fracture dislocation, left shoulder	14 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Mental deficiency without Psychosis	40 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY ward ?	21c. (City or town) (County) (State) Sykesville, Carroll Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8 - 12 - 55 ? M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR? pt. was found to have bruises all over his arm and chest, unable to move left arm

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Thank M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 8/29/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8/29/55	NEW CATHEDRAL	BALTIMORE MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-29-55	[illegible] Deputy	CHARLES F. EVANS & SON	168 W. MT. ROYAL AVE

7697

MARYLAND STATE DEPARTMENT OF HEALTH

07606

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 70

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Taneytown; LENGTH OF STAY (In this place) 1/2 hours.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester 83 X 3
STREET ADDRESS (If rural, give location) 20 Gerrard St.

3. NAME OF DECEASED (Type or Print): (First) RICHARD (Middle) (Last) KNOTT
4. DATE OF DEATH: (Month) Aug (Day) 19 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs Hours	Min.
M.	W.	Divorced	1-25-17	38 yrs.	6	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Valley Food Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (First name unknown) Knott
14. MOTHER'S MAIDEN NAME: Anna Susan Reilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-01-7294
17. INFORMANT AND ADDRESS: Mrs. Anna Highberger Sharpsburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause	(a) Cerebral Hemorrhage	15 Minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James I. Marsh.	Deputy Medical Examiner	Westminster Md	8/19/55.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 22-55	Mt. View Cemetery	Sharpsburg Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 20, 1955	Ethel M Mehring	Edith V. Leaf	Williamsport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

7608

CERTIFICATE OF DEATH

07607

Reg. Dist. No. 78

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) MARTHA (Middle) E (Last) LEE
4. DATE OF DEATH: (Month) aug (Day) 21 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W. | 8. DATE OF BIRTH: July 26 1864 | 9. AGE last birthday: 91 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Husk.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Bumblitz
14. MOTHER'S MAIDEN NAME: Elizabeth alban

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs Howard Elas - Manchester Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
450.0 Immediate cause	(a) Recubitus ulcers	1 month
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture rt hip - Pathological fractures rt femur + left tibial - fibula	3 yrs 2 months
	(c) Arteriosclerosis generalized	5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 8, 1951, to Aug 21, 1955, that I last saw the deceased alive on 7/23, 1955, and that death occurred at 9:40 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. H. Howard	M.D	Manchester, Md	8/22/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug 24-1955	Grace Run	Balto Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 22-55	Mrs. W. P. Denner	Edw A Tipton	Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07608

7609

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1y. 11m. 7days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Y 0 1-4
STREET ADDRESS (If rural give location) 210 N. Madeira St. Baltimore 31. ✓

3. NAME OF DECEASED: (Type or Print) (First) Winfield (Middle) Samuel (Last) Leonard

4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1955 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Jan 6 1875

9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ambrose Leonard

14. MOTHER'S MAIDEN NAME: ? unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS: Mrs. Henrietta Thomas (daughter) 210 N. Madeira St. Baltimore 31

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
IMMEDIATE CAUSE (A) Myocardial infarction — days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Coronary Thrombosis — days
DUE TO (C) Arteriosclerosis Heart disease. — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma Prostate with bone metasteses — yeaxs
Chronic Brain syndrome with Psychotic reaction — years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES X NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23- , 1955 , to 8-30- , 1955, that I last saw the deceased alive on 8-30- , 1955 , and that death occurred at 8.10p M, from the causes and on the date stated above.

SIGNATURE Walther H. Bonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 8-30-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Sept 2/55 — NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery — LOCATION (City, town, or county) Baltimore (State)

DATE REC'D BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE H. W. H. Leach D.R. — 24. FUNERAL DIRECTOR Philip Henry Sons — ADDRESS 202 Eutaw St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07609

7619 CERTIFICATE OF DEATH Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural, Nr. Pleasant Valley
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Westminster, Md. R.D. 7

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Pleasant Valley X
STREET ADDRESS (If rural give location) Westminster, Md. R. D. 7

3. NAME OF DECEASED: (Type or Print) (First) Missouri (Middle) N. (Last) Leppo
4. DATE OF DEATH: (Month) 8/6/55 (Day) (Year) 19
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 11/2/1871
9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife, Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Carroll Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Keefer
14. MOTHER'S MAIDEN NAME: Elizabeth Rodkey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Mrs H. M. Warehime Mrs. H. M. Warehime, Westminster, Md. R.D.7

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
442X Immediate cause	(a) Acute Cardiac Decompensation	2 hrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Cardio. Renal Vascular disease DUE TO	6 yrs
	(c) DUE TO	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-/- ,1955, to 8-6- ,1955, that I last saw the deceased alive on 8-5- ,1955, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Chas. R. Foutz M.D. Westminster Md 8-8-'55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8/9/55
NAME OF CEMETERY OR CREMATORY St. Marys Union Cemetery
LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.
DATE REC'D BY LOCAL REGISTRAR 8-8-55
REGISTRAR'S SIGNATURE Harriet Nusbaum
24. FUNERAL DIRECTOR ADDRESS
J. M. Littlestown, Littlestown, Pa.
R. A. Little Partner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07610

7611

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: Springfield State Hospital
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 4 months 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: 081
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster X
STREET ADDRESS (If rural give location) Route 6 Westminster, Md.

3. NAME OF DECEASED: (First) Marian (Middle) Mac Gill (Last) Mac Gill
4. DATE OF DEATH: (Month) August (Day) 6 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	1-14-1883	72 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Horn
14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Black

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS Mr. Howard Mac Gill (husband) Rt. 6, Westminster, Md. Miss Elizabeth Mac Gill (daughter) 4811 Gwynn Oak Ave. Balt. 7, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

491X
Immediate cause (a) Bronchopneumonia — 3 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. associated with circulatory disturbances, with cerebral arteriosclerosis. Psychosis, Diabetis Mellitus. — Years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1955, to 8-6-, 1955, that I last saw the deceased alive on 8-6-, 1955, and that death occurred at 6.45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or Title) W. H. Tonnenfield M.D
ADDRESS Springfield State Hospital.
DATE SIGNED August 6-55.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF August 9, 1955
NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
LOCATION (City, town, or county) (State) Woodlawn, Maryland

DATE REC'D BY LOCAL REGISTRAR 8-8-55
REGISTRAR'S SIGNATURE C. M. Nedrich
24. FUNERAL DIRECTOR Ellsworth Armacost
ADDRESS Ellsworth Armacost 4600 Liberty Heights Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

7612

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07611

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville — LENGTH OF STAY (in this place): 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hagerstown — 21-03-2
STREET ADDRESS (If rural, give location): Memorial Blvd. East, P.O. Box 764

3. NAME OF DECEASED (Type or Print): (First) HALSIE (Middle) LOUISE (Last) MARSHALL

4. DATE OF DEATH: (Month) 8 (Day) 11 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 6-12-32

9. AGE last birthday: 23 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): College Student

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Marshall

14. MOTHER'S MAIDEN NAME: Halsie Leona Rife

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unk -

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 974X Suffocation — Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hanging by the neck.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenic reaction, chronic undifferentiated type — 1 year & longer

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Hospital — (CITY OR TOWN): Sykesville — (COUNTY): Carroll — (STATE): Md

TIME OF INJURY (Month) 8 (Day) 11 (Year) 55 (Hour) 10:15 p.m. — INJURY OCCURRED While at work ☐ Not while at work ☒ — HOW DID INJURY occur? Hung herself

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

James F Maroney — Deputy Medical Examiner — Westminster Md — 8-12-55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 8/15/1955 — NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY — LOCATION (City, town, or county) (State): HAGERSTOWN, MARYLAND

DATE REC'D BY LOCAL REG.: Aug. 12, 1955 — REGISTRAR'S SIGNATURE: C. Harry Ebert

24. FUNERAL DIRECTOR: C.M. SUTER AND SONS — ADDRESS: HAGERSTOWN, MD

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07612

7613

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linboro (Rural)
LENGTH OF STAY (in this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linboro, Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) ISAAC (Middle) ANDERSON (Last) McINTURFF (Type or Print)

4. DATE OF DEATH: (Month) Aug (Day) 18 (Year) 19 55

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married | 8. DATE OF BIRTH: March 25 1871 | 9. AGE last birthday: 84 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner
10B. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thos S McInturff
14. MOTHER'S MAIDEN NAME: Ann Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-16-3974
17. INFORMANT & ADDRESS: Mrs Chas Ebrhart. Linboro Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertension — 5 yrs

DUE TO (C) Arteriosclerosis — 5 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Act, 19 49, to Aug 18, 19 55, that I last saw the deceased alive on Aug 17, 19 55, and that death occurred at 3:30 P M, from the causes and on the date stated above.

SIGNATURE W N Foard M. D. ADDRESS Manchester Md DATE SIGNED Aug 19-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Aug 21/55
NAME OF CEMETERY OR CREMATORY: Linboro
LOCATION (City, town, or county) (State): Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR: Aug. 19/55
REGISTRAR'S SIGNATURE: Mrs. Wm. Demmer
24. FUNERAL DIRECTOR: Edw C Tipton ADDRESS: Hampstead Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07613

7614 CERTIFICATE OF DEATH Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 2 y 2 m 15 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 18, Md. 3V01-4
STREET ADDRESS (If rural give location) 914 Bonaparte Avenue

3. NAME OF DECEASED: (Type or Print) (First) Mary ~~Elizabeth~~ (Middle) Elizabeth ~~Mary~~ (Last) Mc Namara Mc Namara

4. DATE OF DEATH: (Month) 8 (Day) 20 (Year) 1955

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: January 14th--? unknown
9. AGE last birthday: 83 ? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mose Duval
14. MOTHER'S MAIDEN NAME: Harriett Trembley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (No) (If Yes, give war or dates of service) None
16. SOCIAL SECURITY NO. unkn
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

491X

IMMEDIATE CAUSE (A) Bronchopneumonia — days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chron.brain syndr. ass.with changes of growth senile brain disease with psych.reaction — years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-16-, 1954, to 8-20-, 1955, that I last saw the deceased alive on 8-19-, 1955, and that death occurred at 4 :A M, from the causes and on the date stated above.
SIGNATURE Edmund Leuthans M. D. ADDRESS Springfield State Hospital DATE SIGNED Aug.20, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-22-1955
NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery
LOCATION (City, town, or county) (State) Edmondson Ave.Balto:Md.

DATE REC'D BY LOCAL REGISTRAR 8/20/55
REGISTRAR'S SIGNATURE O. A. Mcleach
24. FUNERAL DIRECTOR ADDRESS George J.Ruth,Inc.-1735 Harford Avenue
George J Ruth Inc #9 D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07614

7615 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 35 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Vol-4
STREET ADDRESS (If rural give location) 1606 Hanover Street

3. NAME OF DECEASED: (Type or Print) (First) Louise (Middle) (Last) Meredith

4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: Un'known | 9. AGE last birthday 74 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Hand | 10B. KIND OF BUSINESS OR INDUSTRY: Unk. | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Meredith | 14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. Unk | 17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSE (B) DUE TO Hypertensive Cardiovascular — 20 years & longer

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Disease

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia — 35 years & longer

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-17, 1920, to 8-4, 1955, that I last saw the deceased alive on 8-4, 1955, and that death occurred at 1045 P M, from the causes and on the date stated above.

SIGNATURE ADDRESS DATE SIGNED
Gerbrud Sonnenfeld M.D. Springfield State Hospital Sykesville Md. 8-4-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8-9-55 | NAME OF CEMETERY OR CREMATORY Mt Olivet | LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 6, 1955 | REGISTRAR'S SIGNATURE C. Harry Weed | 24. FUNERAL DIRECTOR ADDRESS John F. Denny Inc. Laytonsville Montgomery Co.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7616 CERTIFICATE OF DEATH

07615

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville

LENGTH OF STAY (in this place): 29½ years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY:

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Val-4

STREET ADDRESS (If rural give location): Unk -

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
GERTRUDE	E.	MILLER	August	5	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married	1873	82 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Oliver Ewing	Alice Henkle

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	—	Unk.	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
002X Immediate cause	(a) Cerebral Hemorrhage	2 days
DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Arteriosclerosis, general	Years
DUE TO		
	(c) Tuberculosis of lung - far advanced - inactive	2 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Dementia Praecox, paranoid type.	30 yrs. +

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5-13, 1953, to 8-5, 1955, that I last saw the deceased alive on 8-5-, 1955, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Walter O. Townsfield	Springfield State Hospital	8-5-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removed	8-6-55		1217 Eutaw St. Balto. Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 6, 1955	C. Harry Weed	Wm Cook Inc.	1217 E Eutaw St. Balto.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07616

7617 CERTIFICATE OF DEATH Reg. Dist. No. 76

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frizellburg
LENGTH OF STAY (in this place) 65 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster R.D. 7

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carr.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frizellburg
STREET ADDRESS (If rural give location) Westminster R.D. 7

3. NAME OF DECEASED: (Type or Print) (First) CLARENCE (Middle) H. (Last) MYERS

4. DATE OF DEATH: (Month) August (Day) 11, (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: NOV. 14 1889

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer Own farm

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Charles W Myers

14. MOTHER'S MAIDEN NAME: Clara Otto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Lula K. Myers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: ½ hour

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 11, 1955, to Aug 11, 1955, that I last saw the deceased alive on Aug 11, 1955, and that death occurred at 11:10 AM (D.S.T.), from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Julius Chepko M.D. Westminster Md Aug 12, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug 14 1955 NAME OF CEMETERY OR CREMATORY Baust Cemetery LOCATION (City, town, or county) (State) Westminster 7 Md.

DATE REC'D BY LOCAL REGISTRAR 8-13-55 REGISTRAR'S SIGNATURE Harriet Miller

24. FUNERAL DIRECTOR ADDRESS D. Bankard & Son Westminster, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

07617

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

7618

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural, Nr. Silver Run
LENGTH OF STAY (in this place): Few Hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Westminster, Md. R.D.1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Massachusetts; COUNTY: Suffolk
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Allston (Boston) 58X-3
STREET ADDRESS (If rural, give location): 177 Cambridge Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Elwood	Sterling	Nusbaum		8	5	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
Male	White	Married	6/27/1918	37 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Serviced Televisions	T.V. Repair Shop	Carroll Co., Md.	U.S.A.

13. FATHER'S NAME: David S. Nusbaum
14. MOTHER'S MAIDEN NAME: Myrtle Weishaar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service): Yes World War 2
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs Geneva Nusbaum 177 Cambridge St. Allston, Mass.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary Occlusion	Minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Dey) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Marsh	Deputy Medical Examiner	Westminster Md	8/5/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/9/55	Baust Church Cemetery	Nr. Taneytown, Carroll Co. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-8-55	Hamel Miller	J.M. Little, Son R.A. Little Partner.	Littlestown, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07618

CERTIFICATE OF DEATH

7619

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural, Westminster
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Union Mills Westminster, Md. R. D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — Carroll COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster X
STREET ADDRESS (If rural give location): Union Mills Westminster, Md. R. D. 1

3. NAME OF DECEASED: (Type or Print) (First) Leilia (Middle) Miraud (Last) Nusbaum

4. DATE OF DEATH: (Month) (Day) (Year) 8/17/55 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 11/21/1877

9. AGE Last birthday: 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: School Teacher (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Nusbaum

14. MOTHER'S MAIDEN NAME: Mary Earhart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: W. R. Nusbaum Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

581.0
Immediate cause (a) Cirrhosis of liver
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Myocarditis (chr) Syphilis (chr)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 8, 1955 to Aug 17, 1955, that I last saw the deceased alive on Aug 16, 1955, and that death occurred at 5:30 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) W. P. Jamesto MD, ADDRESS Westminster Md DATE SIGNED 8-17-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 8/20/55 — NAME OF CEMETERY OR CREMATORY St. Marys Cemetery — LOCATION (City, town, or county) (State) Silver RUN, Carroll Co., Md

DATE REC'D BY LOCAL REGISTRAR 8-18-55 — REGISTRAR'S SIGNATURE Hamet Miller

24. FUNERAL DIRECTOR J. M. Little & Son — ADDRESS Littlestown, Pa.
Per R. A. Little - Partner.

MARYLAND

7620

07619

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville Maryland. — LENGTH OF STAY (in this place) 6 yr, 7mth, 24dys
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lexinton Park 18 X - 2
STREET ADDRESS (If rural, give location) Lexinton Park

3. NAME OF DECEASED (Type or Print): (First) Ballard (Middle) (Last) Parks.

4. DATE OF DEATH: (Month) August (Day) 6 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7-8-1903

9. AGE last birthday: 52 yrs. — If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City employee-disposal operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Parks

14. MOTHER'S MAIDEN NAME: Rebecca

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
Immediate cause (a) Myocardial Infarction — days

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arteriosclerosis Heart disease — years
026X
(c) Thrombosis of the Coronary artery — days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with C.N.S Syphilis. Pulmonary Tuberculosis — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12-49, 19..., to 8-6-..., 19 55, that I last saw the deceased alive on 8-6-..., 1955, and that death occurred at 9.40 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Townsfield M.D. ADDRESS

DATE SIGNED August 6-55

23. BURIAL, CREMATION, REMOVAL (Specify): Embalmed — DATE Aug 11 1955 — NAME OF CEMETERY OR CREMATORY Union Memorial Park — LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. May 24, 1955 — REGISTRAR'S SIGNATURE C. Harry Perry

24. FUNERAL DIRECTOR — ADDRESS The Anatomy Board of Md per: M. Christie

RGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07620

7621

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Sykesville
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital or institution, give street address or location) Route 2. Sykesville Streaker Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville X
STREET ADDRESS (If rural give location) Route 2 - Sykesville Streaker Road

3. NAME OF DECEASED: (Type or Print) (First) Blanche (Middle) Everett (Last) Pickett

4. DATE OF DEATH: (Month) August (Day) 17 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan. 18, 1894

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Augustus Riggs Bidinger

14. MOTHER'S MAIDEN NAME: Mary Henrietta Ritter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS: Myrtle G. Bidinger Finksburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive Cardiovascular Disease — 6 years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to August, 1955, that I last saw the deceased alive on August 16, 1955, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

SIGNATURE W.B. Culwell M. D. ADDRESS Mt. Airy, Md. DATE SIGNED Aug. 17, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

DATE THEREOF 8-20-1955

NAME OF CEMETERY ~~OR CREMATORY~~ Poplar Springs

LOCATION (City, town, or county) (State) Howard Co., Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 18. 1955

REGISTRAR'S SIGNATURE Robert R. Hurtt.

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

MARYLAND STATE DEPARTMENT OF HEALTH

7622

07621

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 177

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy — LENGTH OF STAY (in this place) 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) Hutchinson (Last) Pickles

4. DATE OF DEATH: (Month) Aug (Day) 25 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: Feb 7 1884

9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: William Henry Pickles

14. MOTHER'S MAIDEN NAME: Mary Ann Hutchinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Gertrude H Pusey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension and

(c) Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN):

(COUNTY):

(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-22-, 1955, to 8-25-, 1955, that I last saw the deceased alive on 8-23-, 1955 and that death occurred at 2 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C M Van Poole M.D. — ADDRESS Mt Airy Md — DATE SIGNED 8-25-55

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE THEREOF 8/29/55 — NAME OF CEMETERY OR CREMATORY Rock Creek Cem — LOCATION (City, town, or county) Washington D C — (State)

DATE REC'D BY LOCAL REG. August 25, 1955 — REGISTRAR'S SIGNATURE Bruce A Rumbley

24. FUNERAL DIRECTOR Frank Heiss — ADDRESS 14th St. Washington, D.C.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07622

7623

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6 mo, 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 12 3701.4
STREET ADDRESS (If rural give location) 1624 Waverly Way

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) Economy (Last) Prempas
4. DATE OF DEATH: (Month) 8 (Day) 6 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: 1870
9. AGE last birthday 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? Naturalized
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Acute myocardial infarction — minutes

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Acute coronary occlusion — minutes
DUE TO, (C) Hypertensive cardiovascular disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. C.B.S. due to cerebral arterio-sclerosis — years

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/4, 1955, to 8/6, 1955 that I last saw the deceased alive on 8/6, 1955, and that death occurred at 3:40 p M, from the causes and on the date stated above.
SIGNATURE Gertrude M. Gross, M.D. M.D. ADDRESS Sykesville, Md DATE SIGNED 8/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-10-55
NAME OF CEMETERY OR CREMATORY Chicago
LOCATION (City, town, or county) (State) Chicago, Ill.

DATE REC'D BY LOCAL REGISTRAR Aug. 7, 1955
REGISTRAR'S SIGNATURE C. Harry Tilson
24. FUNERAL DIRECTOR W. E. Cook Co. ADDRESS 120 18th St. Balto. Md.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07623

7586 CERTIFICATE OF DEATH Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

I

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) about 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 S. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 112 S. Green St.

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) (Last) REED

4. DATE OF DEATH: (Month) Aug. (Day) 12 (Year) 1955

5. SEX: M. 6. COLOR OR RACE: W. 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed 8. DATE OF BIRTH: July 18, 1873 9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Clerk 10b. KIND OF BUSINESS OR INDUSTRY: board of education 11. BIRTHPLACE (State or foreign country): Sandersburg Carroll Co. Md. U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Reed 14. MOTHER'S MAIDEN NAME: Mary Essig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: Mrs. Floyd Spencer, Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion & Myocardial Infarction — Interval Between Onset And Death: 7 Days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio Sclerosis. — years

DUE TO

(c)

420.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 11, 1955, to Aug 12, 1955, that I last saw the deceased alive on Aug. 12, 1955, and that death occurred at 5-25 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
James J. Monk M.D. Westminster Md 8/12/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug. 15, 55 NAME OF CEMETERY OR CREMATORY Lester's Cemetery LOCATION (City, town, or county) (State) Rural, Westminster Md.

DATE REC'D BY LOCAL REGISTRAR 8-14-55 REGISTRAR'S SIGNATURE Harriet Anders 24. FUNERAL DIRECTOR J. F. Myers Jr. ADDRESS Westminster Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07624

Item 9, FilmClob 8-15-55 ec

7624

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville Md.
LENGTH OF STAY (in this place) 28 y
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) C. (Last) Rider
4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):
8. DATE OF BIRTH: 5-12-93
9. AGE last birthday 61 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Anne Arundel County
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George H. Rider
14. MOTHER'S MAIDEN NAME: Cora Seybert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

410X
IMMEDIATE CAUSE (A) Coronary Occlusion — none
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Mitral Stenosis + Insufficiency — about 20 yrs
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia — 28 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1927, to 8-4, 1955, that I last saw the deceased alive on 8-4, 1955, and that death occurred at 8:30 P.M, from the causes and on the date stated above.

SIGNATURE Martin Sorr M.D. M.D. ADDRESS Sykesville, Md. DATE SIGNED August 5-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF Aug. 8 1955
NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY
LOCATION (City, town, or county) (State) BALTIMORE, CITY MARYLAND

DATE REC'D BY LOCAL REGISTRAR 8-5-55
REGISTRAR'S SIGNATURE A. M. Weiland
FUNERAL DIRECTOR Miles Lamoreau
ADDRESS 4510 Liberty Hghts Avenue.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7625

CERTIFICATE OF DEATH

07625

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) 2 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Meadow View Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 83 W. Green St. 27

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) RICHARDS (Last) RIDINGTON

4. DATE OF DEATH: (Month) Aug. (Day) 9 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 5, 1865

9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Preacher

10b. KIND OF BUSINESS OR INDUSTRY: Methodist

11. BIRTHPLACE (State or foreign country): England (Cornwall)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Degonning Ridington

14. MOTHER'S MAIDEN NAME: Phillis Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Dr. Wm. R. Ridington, Westminster Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause (a) Generalized Arteriosclerosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to Aug. 9, 1955, that I last saw the deceased alive on Aug 7, 1955, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) James J. Moser M.D

ADDRESS Westminster Md

DATE SIGNED 8/10/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Aug. 13/55

NAME OF CEMETERY OR CREMATORY Prospect Cemetery

LOCATION (City, town, or county) (State) Mansfield, Penna.

DATE REC'D BY LOCAL REGISTRAR 8-11-55

REGISTRAR'S SIGNATURE Harriet J. Miller

24. FUNERAL DIRECTOR J. S. Myers Jr

ADDRESS Westminster Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07627

7626

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster (Rural)
LENGTH OF STAY (in this place) 17 MON
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY York Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenrock .06X-1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Agnes (Last) Sigman
4. DATE OF DEATH: (Month) Aug (Day) 19 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: May 14-1863
9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (State or foreign country): Carroll Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Rinehart
14. MOTHER'S MAIDEN NAME: Mandilla Herbert

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Clayton Sregman Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 4 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) ? Hypertension — 1 yr.
DUE TO (c) Arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1955, to Aug 19, 1955, that I last saw the deceased alive on Aug 18, 1955, and that death occurred at 4 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. H. Hoard M.D. Manchester Md 8/19/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug. 21, 1955
NAME OF CEMETERY OR CREMATORY Stone Church
LOCATION (City, town, or county) (State) Brodbecks R.D. York Co. Pa.
DATE REC'D BY LOCAL REGISTRAR Aug 19-55
REGISTRAR'S SIGNATURE Mrs. H. P. Sommer
24. FUNERAL DIRECTOR Geo. Heiple ADDRESS Glen Rock Pa.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07628

7627

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

COUNTY CARROLL MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural - Sykesville

LENGTH OF STAY (in this place): 10 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Washington

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sharpsburg 21X-2

STREET ADDRESS (If rural give location): none ✓

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH:	(Month)	(Day)	(Year)
	OTHO	JAMES	SMITH		8	11	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Widowed	unknown	79? yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
unknown	Unk -	USA- Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Otho Smith	Ann — ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Unk -	—	Unk -	Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
592X Immediate cause	(a) Cerebral hemorrhage	8 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO	(b) Hypertensive cardiovascular disease	years
DUE TO	(c) Chronic nephritis, uremia	2 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction — unknown

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3, 19 5, to 8/11, 19 55, that I last saw the deceased alive on 8/11, 19 55 and that death occurred at 3:45 PM DST from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
W. T. Sonnenfield M.D.	Sykesville, Maryland	8/11/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8/13/55	Rose Hill Cem	Hagerstown Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 12, 1955	C. Harry Eberly	H K Hoffman	Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7628 CERTIFICATE OF DEATH

Reg. Dist. No. 07629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville
LENGTH OF STAY (in this place) 2 Y, 11M, 6 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland - Washington COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21.03-2
STREET ADDRESS (If rural give location) 230 Alexander Street ✓

3. NAME OF DECEASED: (Type or Print) (First) IVY (Middle) MYRTLE (Last) SPRANKLE

4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: 2/10/81

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Augustus Sprankle

14. MOTHER'S MAIDEN NAME: Laura Sprankle

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

Immediate cause (a) Cerebral thrombosis — Interval Between Onset And Death: 3 weeks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — years?

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/18, 1955, to 8/4, 1955, that I last saw the deceased alive on 8/4/, 1955, and that death occurred at 8:15 AM DST from the causes and on the date stated above.

SIGNATURE (Degree or title) Walther H. Sonnenschein M.D. ADDRESS Springfield State Hospital DATE SIGNED 8/4/55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF 8/6/55 — NAME OF CEMETERY OR CREMATORY BROADFORDING — LOCATION (City, town, or county) (State) Near Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 5, 1955 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR A.K. Hoffman ADDRESS Hagerstown Md

7629

07630 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville

LENGTH OF STAY (in this place) 17Y 9M 22D

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland 01-02-2

STREET ADDRESS (If rural, give location) 10 N. Lee Street

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) EDITH (Last) STEGMAIER

4. DATE OF DEATH (Month) 8 (Day) 19 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	W	single	6/29/93	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
none	None	Allegany County, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Ignatius Stegmaier	Catherine Matt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
Unk.	-	Unk.	Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
90,3,7 Immediate cause	(a)	Hyperpyrexia	2 Yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Toxemia	4 days
	DUE TO (c)	Fracture of right hip	30 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Mental deficiency — 62 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
Aug 9 - 55	subcapital fracture of right femur.	Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	ward, Hospital	Sykesville	Carroll	Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
7	20	55	P M.			Patient stumbled over another patients feet and fell to floor

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Mason M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 8/19/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-22-55	Cumberland	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 20, 1955	C. Harry Esser	James F. Langfelder	Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07631

7630

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 18 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springf. State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Baltimore
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pundalk 03-53-2
STREET ADDRESS (If rural give location) 1403 North point RD. ✓

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) Josephine (Last) Stormer

4. DATE OF DEATH: (Month) 8 (Day) 7 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) —

8. DATE OF BIRTH: 3-11-85

9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry C. Miller

14. MOTHER'S MAIDEN NAME: Mary Mc Kenna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —
(If Yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Occlusion

ANTECEDENT CAUSE (S):
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Coronary Artery Desease
DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: Sudden Death

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-28, 1937, to 8-7, 1955, that I last saw the deceased alive on 8-6, 1955, and that death occurred at 9 a M, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
Gertrud Sonnenfeld M.D.	Springfield State Hospital Sykesville Md.	9-7-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/11/55	New Cathedral Cem.	4300 Old Frederick Rd.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-8-55	[illegible]	John J. Cavanaugh	96 Collins Ave.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07633

7631 CERTIFICATE OF DEATH Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Westminster
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster, Md. R. D. 3

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Westminster
STREET ADDRESS (If rural give location) Westminster, Md. R. D. 3

3. NAME OF DECEASED: (Type or Print) (First) Milton (Middle) Wesley (Last) Swenk
4. DATE OF DEATH: (Month) 8/5/55 (Day) (Year) 19
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Feb. 10, 1873
9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Farming, Retired
10b. KIND OF BUSINESS OR INDUSTRY: Own farm.
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Swenk
14. MOTHER'S MAIDEN NAME: Susan Bachman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs. Malcolm Stewart Westminster, Md. R-3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
450.0 Immediate cause	(a) Arteriosclerosis generalized with cerebral & coronary failure	10 yrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Myocarditis chronic	3 yrs.
	(c) DUE TO Anemia	1 yr.
		5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to Aug., 1955 that I last saw the deceased alive on Aug 3, 1955 and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Jos. E. Thomassy M.D. Hanover 8-5-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8/8/55
NAME OF CEMETERY OR CREMATORY Bachmans Valley Cemetery
LOCATION (City, town, or county) (State) Nr. Westminster Carroll Co, Md.

DATE REC'D BY LOCAL REGISTRAR 8-5-1955
REGISTRAR'S SIGNATURE Hamel Muller
24. FUNERAL DIRECTOR J. M. Little & Son
ADDRESS Littlestown, Pa.
By R. A. Little Partner.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07634

Items 4,9, FilmG185 8-22-55 et

7632

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 8 m 19 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington 15X-2
STREET ADDRESS (If rural give location) 5013 Strathmore Ave. ✓

3. NAME OF DECEASED: (Type or Print) (First) OSCAR (Middle) (Last) TABLER

4. DATE OF DEATH: (Month) August (Day) 12, (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11-4-81

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Tabler

14. MOTHER'S MAIDEN NAME: Ida Cook

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: ✓

17. INFORMANT & ADDRESS: Mrs. Edith Tabler--wife 5013 Strathmore Ave., Kensington

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cerebral hemorrhage — 5 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypertens. cardiovasc. disease — years
DUE TO (c) C.B.S. of unknown or unspecified cause with psychotic reaction — 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's disease — years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) accid. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) ward (CITY OR TOWN) Sykesville (COUNTY) Carroll (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) about 6/20/55 m. INJURY OCCURED While at Work ☒ Not While At Work ☐ HOW DID INJURY OCCUR? on or about ward, details unkn.

22. I hereby certify that I attended the deceased from 11-24, 1955 to 8-12, 1955, that I last saw the deceased alive on 8-12 1955, and that death occurred at 11:20 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Sommerfield M.D. ADDRESS Spr. St. Hosp. DATE SIGNED 8/12/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug. 5 1955 NAME OF CEMETERY OR CREMATORY Fort Lincoln LOCATION (City, town, or county) (State) Bladensburg Road, Md.

DATE REC'D BY LOCAL REGISTRAR 8/13/55 REGISTRAR'S SIGNATURE A. Nancy Ware 24. FUNERAL DIRECTOR Robt A. Dungan ADDRESS Baltimore - Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07635

7633 CERTIFICATE OF DEATH Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X Marston
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 New Windsor Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marston X
STREET ADDRESS (If rural give location) New Windsor Rural 1

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) NAYLOR (Last) TOWNSHEND

4. DATE OF DEATH: (Month) Aug. (Day) 30 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 9/28/1879

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) farmer retired

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H Townshend

14. MOTHER'S MAIDEN NAME: Julia Naylor

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Martha Townshend, New Windsor, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death: 4 hrs

420.1
Immediate cause (a) Coronary Thrombosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis - Rheumatic
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1955, to Aug 30, 1955, that I last saw the deceased alive on Aug 28, 1955, and that death occurred at 5 PM, from the causes and on the date stated above.
SIGNATURE (Degree or title) J. H. Legg M.D. ADDRESS Union Bridge DATE SIGNED 8-31-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 9/2/55 NAME OF CEMETERY OR CREMATORY Westminster Cem. LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug 31/55 REGISTRAR'S SIGNATURE Essie S Benedict

24. FUNERAL DIRECTOR D. D. Hartzler & Sons ADDRESS New Windsor, Md.